

A note on ethics and the part-timer in occupational health

E V Kuenssberg *General practitioner, Edinburgh*

Editor's note

In the second of an occasional series on ethics in general practice Dr Kuenssberg outlines some of the ethical pitfalls which may trap the unwary general practitioner who also works in an occupational health service.

As a part-time occupational physician based on general practice one straddles two realms of ethics. Their borderlines are imprecise and offer many pitfalls. One has to work hard against the ever ready assumption by employees that one is an agent of management and try to convince them that one is truly concerned with the health and safety problems of the individual. Another major conflict is embodied in one's knowledge of the patient outside the occupational situation and that expected or stipulated by the employer in the work context.

It is a helpful principle to think as oneself as being employed in the role of a consultant, giving advice to management or individuals which they are free to accept or refuse. If, for instance, on assessing a radiation badge analysis report one advises management that the individual should be taken off the job, because of borderline readings, and management do not accept this advice, it may be time to resign. Of course one would have various other duties such as the notification of the Employment Medical Advisory Service (EMAS) and perhaps consultation of colleagues etc., before taking the final step of resigning.

Employees' medical records, kept on the industrial premises, must be securely locked and accessible only to the occupational health nurse or sister or to any specially trained and contractually so detailed clerical staff to handle these records. Open access to first aiders who staff an ambulance or sickroom is certainly not appropriate. First aiders should be required to record separately in the prescribed manner.

Pressures from insurance companies to peruse individual employees' health records is an increasing hazard, and only must be allowed with the individual's consent, and here one's knowledge gained as the general practitioner of a particular employee may require some very careful categorising. An additional obligation is that the medical records of employees who leave or die require the proper ethical standard for their handling. Today when such

a vast amount of as yet untried chemicals and other agents are used in industry, the safe-keeping of such records may well be vital in the interest of workers, as the bladder cancer story among others, illustrates.

One particularly difficult problem seen often is 'the return to work' decision when there may be exaggerated claims of work stress or hazard by the patient. On interviewing employees returning to work from sickness absence, it is depressingly striking how often 30-50 per cent of apparently unnecessary time off work has been certified as necessary absence. While there are occasions where early return to work is wrong in the interests of both the safety of the patient and of the work, as well as in the clinical interest of the employee, often the error lies in the opposite direction. It does not appear to be understood that work on many occasions provides the physiotherapy or occupational therapy needed, particularly where an occupational health service keeps an eye on stresses and strains. This unnecessary certification often results, of course, from the practitioner taking sides and giving his own patient the 'benefit of the doubt', without knowing the work situation, or from unquestioningly accepting the patient's assessment of the employment health hazards. May it be hoped that the present negotiations on short term certification for absence from work will contribute to the solution of this dilemma, by removing an unnecessary step and bringing personnel management and individual commonsense closer together. A sad indicator of the deep lack of coordination of the general practitioner services with the occupational health service is the number of requests for light work received by occupational physicians in cases where the employee concerned is working in a sedentary scrutinising task not involving any physical effort. However, may it be said in mitigation that on very many such occasions it is poor management by those charged with it, which places the various doctors in these unenviable situations.

In this short note it is impossible to do more than pick out some of the outstanding problems which a doctor in an occupational health service will meet. However, it would not be appropriate to conclude without drawing attention to the ethical problem which constantly besets the occupational health doctor. An individual who attends such a doctor for examination may not have come willingly and of

his own accord to seek help and advice, and this is totally different from the normal patient/doctor relationship. Thus the occupational physician will require to be particularly perceptive of the patient's underlying lack of willingness (or otherwise) to

cooperate; in some cases the doctor may have to desist from examinations which might be taken for granted in the ordinary patient/doctor situation, though in practice careful explanation will usually achieve unworrying results.